temperature including advantages, disadvantages and hazards associated with each method. The decision as to which one to employ is left to the resident in charge who in turn uses his or her clinical judgment, depending on the circumstances involved and the particular aspects of each individual case, to decide what is best for the patient.

Finally, the comment was made by Dr. Farrell that the patient who was shown on the CBS Evening News being given the ice treatment died the following day, implying that the method chosen for lowering the body temperature was somehow responsible for hastening this patient's demise. Without going into the details of the case, I must emphasize that this particular patient died from something completely unrelated to her heat illness.

CRAIG R. SAXTON, MD
Junior Assistant Resident, Medicine
Parkland Memorial Hospital
Dallas

REFERENCES

1. Farrell E: Treatment of heat stroke (Correspondence). West J Med 133:255-256, Sep 1980
2. Weiner JS, Khogali M: A physiological body-cooling unit for the treatment of heat stroke. Lancet 1:507-509, Mar 8, 1980
3. Knochel JP: Environmental heat illness: An eclectic review. Arch Intern Med 133:841-864, 1974
4. Knochel JP, Beisel WR, Herndon EG, et al: Renal, cardiovascular, hematologic and serum electrolyte abnormalities of heat stroke. Am J Med 30:299-309, 1961
5. Knochel JP, Dotin LN, Hamburger RJ: Heat stress, exercise and muscle injury: Effects on urate metabolism and renal function. Ann Intern Med 81:321-328, 1974
6. Costrini AM, Pitt HA, Gustafson AB, et al: Cardiovascular and metabolic manifestations of heatstroke and severe heat exhaustion. Am J Med 66:296-302, 1979
7. O'Donnell TF Jr, Clowes GH Jr: The circulatory abnormalities of heat stroke. N Engl J Med 287:734-737, 1972
8. Barcenas C, Hoeffler HP, Lie JT: Obesity, football, dog days and siriasis: A deadly combination. Am Heart J 92:237-244, 1976
9. Callaham ML: When it gets too hot, cool it. Consultant 20: 59-63, Aug 1980

Correction: Hypoglycemia and Accidental Hypothermia

TO THE EDITOR: Due to typing errors in the preparation of my manuscript, "Hypoglycemia and Accidental Hypothermia in an Alcoholic Population" (West J Med 133:105-107, Aug 1980), some inconsistencies are present in the article as published. I wish to correct them.

First, on page 106, under the heading "Patients and Methods," paragraph 2, the second sentence should read as follows: "The highest serum glucose value was *317* mg per dl in a patient with chronic pancreatitis (case 2)." The manuscript stated (incorrectly) "*314* mg per dl" and this figure is not consistent with the data given in Table 1.

Second, the survival statistics quoted in the text are inconsistent with the data in Table 1. Case 10 is listed as "Alive" in the table; that patient, in fact, died. The text is correct.

FAITH FITZGERALD, MD
Office of the Dean
School of Medicine
University of California, Davis

Asymmetrical Hearing Loss

TO THE EDITOR: In the August 1980 issue, Dr. Joseph LaDou reviews the subject of asymmetrical hearing loss in noise-exposed industrial populations.[1] His conclusion, based on a study by Alberti and co-workers,[2] is that "in [cases of] unexplained asymmetrical thresholds, otologic and audiologic consultations should be obtained, as well as vestibular tests, x-ray studies of the temporal bone and advanced hearing tests as indicated." I agree with Dr. LaDou, but feel that his discussion of the data may be misleading and seems to justify an opposite conclusion.

In the study he refers to, 281 patients were evaluated otologically because of pure-tone threshold asymmetries exceeding 15 dB, averaged at 0.5, 1, 2 and 4 kHz. Of these, 108 had extensive workups for retrocochlear disorders, usually including vestibular testing and tomography. Dr. LaDou states that "no treatable disorders were found." In fact, the point of the study was that no treatable *retrocochlear* disorders were found (one arachnoid cyst was discovered). Almost a third of the study group (92/281) had medically or surgically treatable disorders: otosclerosis, otitis media, otitis externa and Meniere disease. Another 54 patients received specific diagnoses other than noise-induced hearing loss or idiopathic sensorineural hearing loss; these included congenital hearing loss, Paget disease, sudden hearing loss and posttraumatic cases. Overall, in more than half the group there were specific diagnoses. Even when medical or surgical treatment is not possible, this information is useful for prognosis, counseling and (obviously) compensation purposes. Presumably, aural rehabilitation and hearing aids were also recommended for many of these patients.

The incidence of specific and treatable diagnoses may be even higher in workers whose asymmetrical hearing thresholds are discovered on routine audiometry as part of an industrial hearing conservation program. Alberti's patients were seen for assessment of compensation, after a noise-exposed career, with an average age of 60.[2]